STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445077	A. BUILDING _____ B. WING _____	02/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNICOI CO NURSING HOME	100 GREENWAY CIRCLE ERWIN, TN 37650

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility documents, observation and interview, the facility failed to ensure safety devices were in place and functioning to prevent falls, and failed to implement recommended new interventions to prevent falls, for one resident (#54) of three residents reviewed for falls, of twenty four residents reviewed; and failed to secure one of two facility supply closets observed. The findings included: Resident #54 was admitted to the facility on August 2, 2013, with diagnoses including Dementia, Atrial Fibrillation, Congestive Heart Failure, and End Stage Renal Disease. Medical record review of the Significant Change Minimum Data Set (MDS) dated December 10, 2013, revealed the resident was cognitively impaired, required extensive assistance with activities of daily living and transfers, and was considered at risk for falls Medical record review of the physician's orders and Treatment Administration Records for	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia Linty — TITLE: Administrator — (X6) DATE: 3/13/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 February 2014, revealed the resident was to have bed and chair alarms in place at all times to prevent falls. Review of facility documents dated February 10, 2014, revealed "...resident found on floor by CNA (Certified Nurse Aide) No alarm was going off, no call light used, resident stated...was going to the BSC (bedside commode) and fell, helped resident to bed, skin assessment, resident stated...did not hit head, no head injury, skin tears on right arm..." Observation and interview of the resident, on February 19, 2014, in the resident's room during wound care, revealed the resident with three small skin tears to the right forearm. The resident reported during interview no significant pain, and no complications related to the injuries. The resident stated "I got up and I fell and cut it" Interview with the MDS Coordinator and Patient Safety Officer, on February 20, 2014, at 12:52 p.m., in the MDS office confirmed at the time of the fall the resident alarm was in use and did not sound. Observation on initial tour February 18, 2014, at 11:20 a.m., revealed the door to the supply room in the main hallway was unlocked. Inside the room were stored four Total Body Shampoo 4 ounce (oz.) bottles, four Hand and Body Lotion 4 oz. bottles, five Johnson Baby Shampoo 1.5 oz. bottles, and seven Baby Powder 4 oz. bottles. All items were labeled "Keep out of reach of children." Continued observation revealed several residents in wheelchairs traveling between the main dining room and the main hallway, passing the storage room.	F 323	F323 Random current alarm audit was conducted by assigned licensed staff 100% compliance for all alarms. Completion Date: 3/12/14. **Monitoring** Assigned licensed staff will conduct weekly audits to ensure current alarms are present and functioning correctly. Audits will be reviewed during the QAPI meeting for 3 months. Maintenance Director installed locking doorknob on supply room door. Completion Date: 2/21/14 **Monitoring** Maintenance Director will audit weekly to ensure door is locked. Audits will be reviewed during the QAPI meeting for 3 months.	

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F 323	Continued From page 2 Interview with the Director of Nursing (DON) on February 18, 2014, at 11:22 a.m., confirmed the door was unlocked and residents could enter the room.	F 323	F514 The current Infection control program is in compliance with the applicable stand of care, but that in order to respond to the citation from the surveyors, the facility is taking the following additional actions: Currently staff members will be in-serviced on the Infection Control Program by 3/31/13 2014 as it relates to the prevention of infections, isolation, proper storage of a record of incident and corrective action related to infection and proper handling of linen. Current staff members will attend a Hand Hygiene education by 3/31/14 Completion Date: 3/31/14 **Monitoring** Designated licensed staff member will conduct weekly hand hygiene audits. Audits will be reviewed during the QAPI meeting for 3 months.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		

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F 441	Continued From page 3 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and interview, the facility failed to maintain hand hygiene during the meal pass on one of two wings observed. The findings included: Observation on the 100 wing, on February 18, 2014, from 12:35 p.m. to 1:05 p.m., revealed two Certified Nursing Aides (CNAs) distributing meal trays to the residents. Observation of CNA #1 from 12:45 p.m. to 12:55 p.m. revealed CNA #1 entered room 126 and set up a meal tray for a resident, made contact with the resident's over bed table, and clothing, exited the room without washing the hands, returned to the meal cart, accessed the ice cooler beside the meal cart, obtained ice from the cart with a scoop, and returned to room 126. Continued observation revealed CNA #1 exited room 126 a second time without washing the hands, returned to the meal cart, obtained a food tray from the cart, and entered room 131. Continued observation revealed CNA #1 set up the meal tray for the resident in room 131 and touched the resident, and exited the room, without washing the hands.	F 441		

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F 441	Continued From page 4 Continued observation on the 100 wing, from 12:55 p.m. to 1:10 p.m. revealed CNA #2 entered room 124, made contact with the resident, and exited the room without washing the hands. Continued observation revealed CNA #2 next entered room 127, made contact with the resident, picked up the meal tray, exited the room with the tray, delivered it to the meal cart, and proceeded to the nursing station without washing the hands. Continued observation at 1:00 p.m. revealed CNA #2 picked up an ink pen lying on a clipboard, documented care on a clipboard, and then entered room 128 without washing the hands. Continued observation revealed CNA #2 exited room 128, and proceeded to room 121 and entered without washing the hands, picked up a meal tray, delivered it to the meal cart in the hallway, and proceeded to the staff lounge, without washing the hands. Continued observation at 1:10 p.m. in the 100 hallway nursing station revealed CNA #1 documenting care on the same clipboard, using the same pen lying atop it, used previously by CNA #2. Review of the facility policy Infection Control for Long Term Care Residents and Staff, effective August 1985, reviewed May 23, 2011, revealed, "... hand hygiene is practiced between each resident..." Interview with the 100 hallway charge nurse, at 1:11 p.m., in the nursing station, confirmed hands were to be washed upon entering and exiting resident rooms or between resident contacts, or when hands were visibly soiled, and confirmed the facility failed to maintain hand hygiene during	F 441		

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F 441	Continued From page 5 the lunch tray pass.	F 441		
F 514 SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, and interview, the facility failed to maintain resident records in a systematically organized, complete, accurate, and readily accessible format for four residents, (#37, #53, #54 and #58) of sixty resident records reviewed, and for five of thirty closed records for residents (#18, #32,#46, #66, #68) reviewed. The findings included: Resident #37 was admitted to the facility on February 7, 2013, with diagnoses of Multiple Falls, Atrial Fibrillation, Spinal Stenosis, Chronic Back Pain, Arthritis, Dementia and history of Deep Vein Thrombosis. Medical record review of the care plan dated	F 514	F514 Current resident supplements were added to the MAR as of 2/26/14 to allow Licensed Staff to document consumption or refusal and allowing percent of intake to be documented. Completion Date: 2/26/14 **Monitoring** Registered Dietitian will conduct weekly audits to ensure supplements are being documented. Audits will be reviewed during the QAPI meeting for 3 months. Developed plan for the organization and storage of discharged records on 3/13/14.	

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F 514	Continued From page 6 February 18, 2013, revealed "...care plan developed pt (patient) cont (continues) on soft mech (mechanical) diet...supplements will be added..." Medical record review of the care plan dated March 14, 2013, revealed "...supplements were added..." Medical record review of the physician order dated July 19, 2013, revealed "...ensure (supplement) liq (liquid) vanilla give by mouth with meals 3 times daily..." Medical record review of the care plan dated January 3, 2014, revealed "...cont on soft diet /c (with) supplementation..." Observation of the resident on February 18, 2014, at the lunch meal in the dining room revealed the resident at the dining table eating pizza that had been brought in by a visitor for a couple of residents. The resident consumed one slice of pizza. The Certified Nurse Aide (CNA) brought the residents tray to the resident at the table. The resident refused the tray and said was eating pizza for lunch. The supplement and a milkshake were on the tray. The CNA offered the supplement and the milkshake to the resident who refused and stated "will drink them at supper" Resident #53 was admitted to the facility on December 18, 2013, with diagnoses including Allergic Reaction to Iron Infusion, Acute on Chronic Kidney Disease Stage 3, Diabetes Mellitus 2, Iron Deficiency Anemia, Cardiomyopathy, Glaucoma, Hypothermia, Shock, Myocardial Infarction, Congestive Heart	F 514		

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F 514	Continued From page 7 Failure and Chronic Obstructive Pulmonary Disease. Medical record review of the physician orders dated January 10, 2014, revealed "...add glucerna (a supplement) to meals twice daily per dietician recommendation..." Medical record review of the dietary assessment dated January 15, 2014, revealed "...diet regular /c glucerna bid (twice a day)..." Medical record review of the nursing monthly summary dated January 19, 2014, revealed "...eating habits usually good appetite" Medical record review of the physician progress note dated January 23, 2014, revealed "...appetite is good and has started some supplements to aid in weight..." Interview with Licensed Practical Nurse #2, on February 19, 2014, at 9:30 a.m., in the side two nursing station revealed nursing doesn't document the supplement intakes, dietary puts them on the meal trays and delivers them. "The CNA's add up the fluid intake and count it all together." Interview with CNA #3 on February 21, 2014, at 12:30 p.m., in the side two nursing station revealed "we add all the liquids together and count them, we don't separate them." Interview with the Director of Nursing (DON) on February 21, 2014, at 12:50 p.m., in the DON office revealed "...supplements aren't documented anywhere, they come on the trays labeled what they are but then all the liquids are	F 514		

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F 514	Continued From page 8 added together for intake..." Resident #54 was admitted to the facility on August 2, 2013, with diagnoses, including Dementia, Atrial Fibrillation, Congestive Heart Failure, and End Stage Renal Disease. Medical Record review of the Significant Change Minimum Data Set (MDS) dated December 10, 2013, revealed the resident was cognitively impaired, required extensive assistance with activities of daily living and transfers, and was considered at risk for falls. Continued review of the physician's orders and Treatment Administration Records for February 2014, revealed the resident was to have bed and chair alarms in place at all times to prevent falls. Review of facility document dated February 10, 2014, revealed the consultant pharmacist reviewed the resident medications and recommended evaluation of the resident's blood pressure for symptoms of orthostatic hypotension (a sudden drop in blood pressure caused by change in body position associated with some combinations of medications). Continued medical record review revealed no indication the facility carried out the consultant pharmacist's recommendations to evaluate the resident for symptoms of orthostatic hypotension after the fall. Interview with the MDS Coordinator and Patient Safety Officer, on February 20, 2014, at 12:52 p.m., in the MDS office revealed, the recommendations of the pharmacist were made in an electronic format, which was not accessible to the facility clinical staff. Continued interview	F 514	F514 Pharmacist will call the MDS Coordinator and/or designated licensed staff member to communicate Pharmacist. Completion Date: 2/26/14 **Monitoring** Designated licensed staff member will conduct weekly audits of current resident records to ensure recommendations are being communicated and documented appropriately Audits will be reviewed during the QAPI meeting for 3 months.	

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F 514	Continued From page 9 revealed the electronic communications and recommendations made by the consultant pharmacist could not be printed by the facility management, or clinical staff. Continued interview revealed the recommendations were to have been transcribed by the MDS coordinator into a written format and included in the facility's paper medical record for review by the clinical staff. Continued interview revealed the MDS coordinator was unaware of the recommendations made by the pharmacist as no electronic means to alert the MDS coordinator of the recommendations was in place. Continued interview revealed the recommendations were forwarded electronically to the facility risk management department, and were not transcribed into the facility clinical staff's paper medical records, nor were those recommendations from the risk management department electronically accessible to the clinical staff. Continued interview confirmed the MDS coordinator had failed to forward the consultant pharmacist's recommendations to the nursing staff, and the facility failed to implement the new intervention to prevent falls. Continued interview confirmed the facility's medical record for resident was incomplete, not systematically organized, accurate, or readily accessible. Closed record review of thirty residents' charts revealed five closed records of thirty closed records reviewed contained only printed partial MDS information and had to be returned to the Medical Record department to retrieve the full closed records. Interview with the Safety Officer, in the conference room on February 20, 2014, at 1:30 p.m, in the conference room confirmed the	F 514	F514 Current Medical Record staff members will be in-serviced on 3/20/14 on the process. Competition Date: 3/31/14 **Monitoring** Medical Records manager will conduct weekly audits to ensure discharge records are being organized and stored correctly. Audits will be reviewed during the QAPI meeting for 3 months.	

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F 514	Continued From page 10 records were not complete and records were unorganized and often difficult to access, "We know we have a problem." Resident #58 was admitted to the facility December 13, 2013, with diagnoses including Right Femoral Neck Fracture with Arthroplasty, Coronary Artery Disease, Diabetes, Hypertension, Hypothyroidism, Chronic Renal Insufficiency, and Generalized Weakness. Medical record review of the Dietary Progress Notes dated December 23, 2013, revealed "...only eating 40% at meals...Rec (receives) glucerna TID (three times daily) to...(increase) cal/protein intake..." Medical record review of the Flowsheet View Report dated December 13, 2013 to February 7, 2014, revealed no entry for Glucerna (a diabetic protein and calorie supplement) nor the specific amount of the Glucerna consumed by the resident. Interview with the Registered Dietician, (RD) on February 20, 2014, at 1:10 p.m., in the conference room, confirmed supplement consumption was not documented by the nursing staff and the Registered Dietician was unable to determine if the supplement was effective or ineffective unless the resident continued to lose weight.	F 514		